The Tulalip Tribes
Medical Expense Reimbursement Flex Spending Account
Reimbursement Claim Form

Employee Name: _____ SS# _____-_____-_____

Address: _____

City/State/Zip: _____

Instructions

1. For medical/dental expense claims that were submitted to a medical plan or an insurance company but not paid by that carrier, attach copies of other insurance carrier claim and/or payment forms (explanation of benefits forms) to establish amounts not covered under the medical/dental plan.

2. For all other reimbursable expenses, copies of all bills must be attached which show who (name and address) rendered the service, reason for charge and date and amount of charge. Canceled checks are not acceptable receipts.

3. Submit this form (retain a copy for your records) by mail or fax to:
   CBSolutions LLC Fax: 425-391-9715
   ATTN: Flex Plan Administrator
   160 NW Gilman Blvd. Ste. 3
   Issaquah, WA 98027

Expenses

Expenses (list below)

Item	Date Expense Paid	Reason for Payment**	Amount Paid
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

** Use the following letter designation for "Reasons for Payment":

A. medical/dental expense submitted to insurance company but not paid by the carrier (for example; a co-insurance or deductible amount)
B. medical/dental expense not covered by a benefit plan
C. optical expenses

Employee Certification

I certify that all items requested to be reimbursed comply with The Tulalip Tribes Administration Flexible Spending Account Program and such items have not and will not be covered by any other plan or program of any employer or other person. The Tulalip Tribes Administration does not accept responsibility for direct payment to any individuals other than the employee.

Employee Signature _____ Date: _____